		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044263

Facility Name: GILMAN NURSING PAVILION

Address: ROUTE 45 SOUTH (Number) GILMAN (City) 60938 (Zip Code)

County: IROQUOIS

Telephone Number: (847) 679 - 8219 **Fax #** (847) 679 - 7377

IDPA ID Number: 36 - 4264598

Date of Initial License for Current Owners: 01/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
			"Sub-S" Corp.				
		X	Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	307		1,826	2,133	8
9	SNF/PED					9
10	ICF	19,619	9,242	427	29,288	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,926	9,242	2,253	31,421	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.95%

D. How many bed-hold days during this year were paid by Public Aid?
22 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 7 and days of care provided 1,826

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	159,525	11,744	5,351	176,620		176,620	0	176,620			1
2	Food Purchase		131,736		131,736	(15,586)	116,150	(1,529)	114,621			2
3	Housekeeping	87,597	16,864	0	104,461		104,461	0	104,461			3
4	Laundry	30,144	13,255	1,329	44,728		44,728	0	44,728			4
5	Heat and Other Utilities			81,227	81,227		81,227	576	81,803			5
6	Maintenance	38,062	33,036	4,599	75,697		75,697	6,545	82,242			6
7	Other (specify):*			5,968	5,968		5,968	876	6,844			7
8	**TOTAL General Services**	315,328	206,635	98,474	620,437	(15,586)	604,851	6,468	611,319			8
	B. Health Care and Programs											
9	Medical Director	0		1,200	1,200		1,200	0	1,200			9
10	Nursing and Medical Records	1,132,262	45,732	1,529	1,179,523		1,179,523	0	1,179,523			10
10a	Therapy	0	1,582	6,154	7,736		7,736	0	7,736			10a
11	Activities	91,101	6,251	617	97,969		97,969	0	97,969			11
12	Social Services	32,311		1,386	33,697		33,697	0	33,697			12
13	Nurse Aide Training			1,062	1,062		1,062	90	1,152			13
14	Program Transportation			403	403		403	0	403			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,255,674	53,565	12,351	1,321,590	0	1,321,590	90	1,321,680			16
	C. General Administration											
17	Administrative	68,648		0	68,648		68,648	111,473	180,121			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			29,788	29,788		29,788	712	30,500			19
20	Dues, Fees, Subscriptions & Promotions			36,597	36,597		36,597	(28,015)	8,582			20
21	Clerical & General Office Expenses	28,392	21,302	173,126	222,820		222,820	(125,233)	97,587			21
22	Employee Benefits & Payroll Taxes			342,809	342,809	15,586	358,395	0	358,395			22
23	Inservice Training & Education			0	0		0	0	0			23
24	Travel and Seminar			3,607	3,607		3,607	642	4,249			24
25	Other Admin. Staff Transportation			7,734	7,734		7,734	82	7,816			25
26	Insurance-Prop.Liab.Malpractice			77,893	77,893		77,893	2,595	80,488			26
27	Other (specify):*			0	0		0	17,821	17,821			27
28	**TOTAL General Administration**	97,040	21,302	671,554	789,896	15,586	805,482	(19,923)	785,559			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,668,042	281,502	782,379	2,731,923	0	2,731,923	(13,365)	2,718,558			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GILMAN NURSING PAVILION #0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			37,492	37,492		37,492	(7,384)	30,108			30
31	Amortization of Pre-Op. & Org.			1,720	1,720		1,720	0	1,720			31
32	Interest			25,324	25,324		25,324	1,222	26,546			32
33	Real Estate Taxes			42,065	42,065		42,065	1,357	43,422			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	0	480,000			34
35	Rent-Equipment & Vehicles			7,866	7,866		7,866	5,554	13,420			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			594,467	594,467	0	594,467	749	595,216			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		41,712	80,265	121,977		121,977	0	121,977			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			54,203	54,203		54,203	0	54,203			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	41,712	134,468	176,180	0	176,180	0	176,180			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,668,042	323,214	1,511,314	3,502,570	0	3,502,570	(12,616)	3,489,954			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,826)	30		9
10	Interest and Other Investment Income	(175)	32		10
11	Discounts, Allowances, Rebates & Refunds	(566)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(963)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(2,750)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(584)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(26,052)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	0			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,916)		$ 0	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	28,300		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 28,300		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (12,616)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GILMAN NURSING PAVILION

ID# 0044263

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GILMAN NURSING PAVILION **#** 0044263 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,529)	0	0	0	0	0	0	0	0	0	0	(1,529)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	576	0	0	0	0	0	0	0	0	576	5
6	Maintenance	0	0	2,984	3,561	0	0	0	0	0	0	0	6,545	6
7	Other (specify):*	0	0	616	0	260	0	0	0	0	0	0	876	7
8	**TOTAL General Services**	(1,529)	0	4,176	3,561	260	0	0	0	0	0	0	6,468	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	90	0	0	0	0	0	0	0	0	90	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	90	0	0	0	0	0	0	0	0	90	16
	C. General Administration													
17	Administrative	0	0	0	111,473	0	0	0	0	0	0	0	111,473	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(584)	0	1,296	0	0	0	0	0	0	0	0	712	19
20	Fees, Subscriptions & Promotions	(28,802)	0	787	0	0	0	0	0	0	0	0	(28,015)	20
21	Clerical & General Office Expenses	0	(160,780)	32,049	3,498	0	0	0	0	0	0	0	(125,233)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	642	0	0	0	0	0	0	0	0	642	24
25	Other Admin. Staff Transportation	0	0	82	0	0	0	0	0	0	0	0	82	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,595	0	0	0	0	0	0	0	0	2,595	26
27	Other (specify):*	0	0	5,168	0	12,653	0	0	0	0	0	0	17,821	27
28	**TOTAL General Administration**	(29,386)	(160,780)	42,619	114,971	12,653	0	0	0	0	0	0	(19,923)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,915)	(160,780)	46,885	118,532	12,913	0	0	0	0	0	0	(13,365)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,826)	0	2,442	0	0	0	0	0	0	0	0	(7,384)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(175)	0	1,397	0	0	0	0	0	0	0	0	1,222	32
33	Real Estate Taxes	0	0	1,357	0	0	0	0	0	0	0	0	1,357	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	5,554	0	0	0	0	0	0	0	0	5,554	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(10,001)	0	10,750	0	0	0	0	0	0	0	0	749	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,916)	(160,780)	57,635	118,532	12,913	0	0	0	0	0	0	(12,616)	45

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING FEES	$ 160,780	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (160,780)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 160,780			$	$ * (160,780)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 576	$ 576	15
16	V	6	REPAIRS & MAINT.		" " "	100.00%	2,984	2,984	16
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	616	616	17
18	V	13	NURSES AIDE TRAINING		" " "	100.00%	90	90	18
19	V	19	PROFESSIONAL FEES		" " "	100.00%	1,296	1,296	19
20	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	787	787	20
21	V	21	CLERICAL & GENERAL		" " "	100.00%	32,049	32,049	21
22	V	24	SEMINARS AND TRAVEL		" " "	100.00%	642	642	22
23	V	25	ADMIN. STAFF TRANS		" " "	100.00%	82	82	23
24	V	26	INSURANCE		" " "	100.00%	2,595	2,595	24
25	V	27	EMP BEN. - GEN ADMIN.		" " "	100.00%	5,168	5,168	25
26	V	30	DEPRECIATION		" " "	100.00%	2,442	2,442	26
27	V	32	INTEREST		" " "	100.00%	1,397	1,397	27
28	V	33	REAL ESTATE TAXES		" " "	100.00%	1,357	1,357	28
29	V	35	EQUIPMENT RENTAL		" " "	100.00%	5,554	5,554	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 57,635	$ * 57,635	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 3,561	$ 3,561	15
16	V	10	NURSING CMP - SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	22,135	22,135	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	29,908	29,908	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%	25,560	25,560	19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%	6,367	6,367	21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%	7,194	7,194	22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	7,746	7,746	25
26	V	17	ADMIN. CMP. - H. ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	12,563	12,563	27
28	V	21	CLERICAL CMP. - S. AARON		" " "	100.00%	3,498	3,498	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 118,532	$ * 118,532	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 260	$ 260	15
16	V		15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V		27	EMP. BEN. - M. MAUER		" " "	100.00%	1,413	1,413	17
18	V		27	EMP. BEN. - M. AARON		" " "	100.00%	2,062	2,062	18
19	V		27	EMP. BEN. - F. AARON		" " "	100.00%	2,937	2,937	19
20	V		27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V		27	EMP. BEN. - S. KOPLIN		" " "	100.00%	1,460	1,460	21
22	V		27	EMP. BEN. - D. MAGAFAS		" " "	100.00%	1,548	1,548	22
23	V		27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V		27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V		27	EMP. BEN. - S. LEVY		" " "	100.00%	1,075	1,075	25
26	V		27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V		27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,689	1,689	27
28	V		27	EMP. BEN. - S. AARON		" " "	100.00%	469	469	28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 12,913	$ * 12,913	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC REHAB CONSULTANTS LLC		$	$	15
16	V	19	PROFESSIONAL FEES		" " "				16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V	10	NURSING & MEDICAL SUPP		PHARMCOR LLC				20
21	V	19	PROFESSIONAL FEES		" "				21
22	V	21	CLERICAL & GENERAL		" "				22
23	V	22	EMPLOYEE BENEFITS		" "				23
24	V	39	ANCILLARY EXPENSE		" "				24
25	V								25
26	V								26
27	V	10	MEDICAL SUPPLIES		LINCOLN MEDICAL SUPPLIES, INC.				27
28	V	39	ANCILLARY EXPENSE		" " "				28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MARSHALL MAUER		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 22,135	17-7	1
2	MAURY AARON		ADMINISTRATIVE					SALARY	29,908	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	25,560	17-7	3
4	STEVE LEVY		ADMINISTRATIVE					SALARY	6,367	17-7	4
5	SUSAN KOPLIN HARAMARAS		ADMINISTRATIVE					SALARY	7,746	17-7	5
6	SHARON AARON		CLERICAL					SALARY	3,498	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 95,214		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679 - 8219
Fax Number: ((847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	577,359	14	$ 10,580	$	31,421	$ 576	1
2	6	REPAIRS & MAINT	" "	577,359	14	54,834	37,633	31,421	2,984	2
3	7	EMP. BEN. - GEN. SVC.	" "	577,359	14	11,326		31,421	616	3
4	13	NURSES AIDE TRAINING	" "	577,359	14	1,650		31,421	90	4
5	19	PROFESSIONAL FEES	" "	577,359	14	23,811		31,421	1,296	5
6	20	DUES & SUBSCRIPTIONS	" "	577,359	14	14,469		31,421	787	6
7	21	CLERICAL & GENERAL	" "	577,359	14	588,891	487,646	31,421	32,049	7
8	24	SEMINARS & TRAVEL	" "	577,359	14	11,803		31,421	642	8
9	25	ADMIN. STAFF TRANS.	" "	577,359	14	1,502		31,421	82	9
10	26	INSURANCE	" "	577,359	14	47,685		31,421	2,595	10
11	27	EMP.BEN. - GEN. ADMIN.	" "	577,359	14	94,969		31,421	5,168	11
12	30	DEPRECIATION	" "	577,359	14	44,866		31,421	2,442	12
13	32	INTEREST	" "	577,359	14	25,667		31,421	1,397	13
14	33	REAL ESTATE TAXES	" "	577,359	14	24,936		31,421	1,357	14
15	35	EQUIPMENT RENTAL	" "	577,359	14	102,054		31,421	5,554	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,043	$ 525,279		$ 57,635	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679 - 8219
Fax Number: ((847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	12	$ 62,194	$ 62,194	2	$ 3,561	1
2	10	NURSING - SUE G.	" "	40	1	45,894	45,894		0	2
3	17	ADMIN. CMP. - M. MAUER	" "	40	13	398,821	398,821	2	22,135	3
4	17	ADMIN. CMP. - M. AARON	" "	45	12	521,536	521,536	3	29,908	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	191,700	191,700	6	25,560	5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	50	3	161,003	161,003		0	6
7	17	ADMIN. CMP. - S. KOPLIN	" "	45	8	71,993	71,993	4	6,367	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	8	81,938	81,938	4	7,194	8
9	17	ADMIN. CMP. - E. CASSON	" "	38	1	47,846	47,846		0	9
10	17	ADMIN. CMP. - S. BOGEN	" "	45	3	96,858	96,858		0	10
11	17	ADMIN. CMP. - S. LEVY	" "	55	13	139,807	139,807	3	7,746	11
12	17	ADMIN. CMP. - H. ALTER	" "	40	1	9,000	9,000		0	12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	13	219,069	219,069	3	12,563	13
14	21	CLERICAL CMP. - S. AARON	" "	40	13	63,022	63,022	2	3,498	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,110,681	$ 2,110,681		$ 118,532	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679 - 8219
Fax Number: ((847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP BEN - D. NEHMER	WGHTD. AVG. HOURS	40	12	$ 4,545	$	2	$ 260	1
2	15	EMP BEN - SUE G.	" "	40	1	3,924			0	2
3	27	EMP BEN - M. MAUER	" "	40	13	25,461		2	1,413	3
4	27	EMP BEN - M. AARON	" "	45	12	35,957		3	2,062	4
5	27	EMP BEN - F. AARON	" "	45	6	22,028		6	2,937	5
6	27	EMP BEN - S. GOLDSTEIN	" "	50	3	20,193			0	6
7	27	EMP BEN - S. KOPLIN	" "	45	8	16,504		4	1,460	7
8	27	EMP BEN - D. MAGAFAS	" "	45	8	17,632		4	1,548	8
9	27	EMP BEN - E. CASSON	" "	38	1	11,976			0	9
10	27	EMP.BEN. - S. BOGEN	" "	45	3	6,849			0	10
11	27	EMP BEN - S. LEVY	" "	55	13	19,408		3	1,075	11
12	27	EMP BEN - H. ALTER	" "	40	1	1,068			0	12
13	27	EMP BEN - NON-OWNER	" "	45	13	29,449		3	1,689	13
14	27	EMP BEN - S. AARON	" "	40	13	8,457		2	469	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 223,451	$		$ 12,913	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS LI
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 679 - 8219
Fax Number: ((847) 679 - 7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES								5
6										6
7		PHARCOR LLC								7
8	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION							8
9	19	PROFESSIONAL FEES	" "							9
10	21	CLERICAL & GENERAL	" "							10
11	22	EMPLOYEE BENEFIT								11
12	39	ANCILLARY EXPENSE								12
13										13
14		LINCOLN MEDICAL SUPPLIES								14
15	10	MEDICAL SUPPLIES	DIRECT ALLOCATION							15
16	39	ANCILLARY EXPENSE	" "							16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 0	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	SUCCESS BANK		X	WORKING CAPITAL				456,127		PRIME+	25,324	6
7												7
8	RELATED PARTY	X									1,397	8
9	TOTAL Facility Related						$ 0	$ 456,127			$ 26,721	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 456,127			$ 26,721	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 41,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 41,065	2
3. Under or (over) accrual (line 2 minus line 1).	$ 65	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 42,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 42,065	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999	39,958	11
2000	41,065	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GILMAN NURSING PAVILION COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0044263

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-C-23-07-226-004	NURSING HOME	$ 41,064.68	$ 41,064.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 41,064.68	$ 41,064.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 8,600
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 1,720
4. Dates Incurred: 1/99

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8					24,142	619	35	690	71	5,748	8
	Improvement Type**										
9	SECURITY CAMERAS			1999	3,500	90	39	90		236	9
10	AIR SYSTEM IN KITCHEN			1999	1,200	31	39	31		66	10
11	FIRE DOOR			1999	8,757	225	39	225		515	11
12	FLOOR TILE, VINYL, WALLPAPER			1999	47,922	1,229	39	1,229		2,651	12
13	BLINDS/CURTAINS			2000	473	116	7	116		128	13
14	PICKET FENCE IMPROVEMENTS			2000	957	64	7	64		88	14
15	WALLPAPER/HANDRAILS/BUMPERGUARDS			2000	62,558	2,276	27.5	2,276		4,047	15
16	NURSE STATION			2000	29,619	1,077	27.5	1,077		1,912	16
17	ROOM /COMMON AREA SIGNS			2000	2,761	100	27.5	100		167	17
18	AIR CONSITIONER/COMPRESSOR			2000	5,096	185	27.5	185		319	18
19	WINDOW/DOOR			2000	3,011	109	27.5	109		209	19
20	WATER HEATER/ VALVE			2000	2,492	91	27.5	91		158	20
21	SOFFIT/FACIA REPAIR			2000	9,746	354	27.5	354		380	21
22	GAS LINE INSTALLATION			2000	3,119	113	27.5	113		212	22
23	WATER HEATERS/WATER SOFTENERS			2001	13,740	228	27.5	228		228	23
24	WINDOWS			2001	1,493	13	27.5	13		13	24
25	WALL CABINET			2001	743	1	27.5	1		1	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 221,329	$ 6,921		$ 6,992	$ 71	$ 17,078	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 94,890	$ 19,157	$ 9,489	$ (9,668)	10 YRS	$ 19,957	71
72	Current Year Purchases	20,070	1,737	1,003	(734)	10 YRS	1,003	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	14,337	1,656	1,368	(288)		7,693	74
75	TOTALS	$ 129,297	$ 22,550	$ 11,860	$ (10,690)		$ 28,653	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 FORD BUS	2001	$ 51,478	$ 10,296	$ 10,296	$ 0	5	$ 10,296	76
77				3,064	167	960	793		1,104	77
78							0			78
79							0			79
80	TOTALS			$ 54,542	$ 10,463	$ 11,256	$ 793		$ 11,400	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 405,168	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,934	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,108	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,826)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 57,131	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GILMAN ASSOCIATES

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		99	1/1/99	$ 480,000	20		3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 480,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 6,556 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	98 CADILLAC SEVILLE	$ 685.00	$ 2,055	17
18	ADMINISTRATOR	01 HONDA ACCORD LX	339.00	2,712	18
19	PAYROLL DEDUCTION			(3,457)	19
20					20
21	TOTAL		$ 1,024.00	$ 1,310	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,152	$	$ 1,152
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 1,152	$ 0	$ 1,152
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,152			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 21,616	$		$ 21,616	1
2	Licensed Speech and Language Development Therapist		hrs			1,667			1,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			55,321			55,321	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				37,350		37,350	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB & SUPPLIES						6,023		6,023	13
14	TOTAL			$		$ 78,604	$ 43,373		$ 121,977	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GILMAN NURSING PAVILION **#** 0044263 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	658,951		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,209		6
7	Other Prepaid Expenses	2,133		7
8	Accounts Receivable (owners or related parties)	61,600		8
9	Other(specify): RE TAX & INSUR ESCROW	69,026		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 820,919	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	197,187		15
16	Equipment, at Historical Cost	166,437		16
17	Accumulated Depreciation (book methods)	(82,686)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	8,600		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,160)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSIT	237,600		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 521,978	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,342,897	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 164,572	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	494,079		29
30	Accrued Salaries Payable	163,232		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,566		31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,000		32
33	Accrued Interest Payable	3,100		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 874,549	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 874,549	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 468,348	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,342,897	$ 0	48

***(See instructions.)**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 502,184	1
2	Restatements (describe):		2
3	IL REPLACEMENT TAX	(1,716)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 500,468	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	27,280	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(59,400)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (32,120)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 468,348	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,481,034	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,481,034	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	48,075	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 48,075	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	175	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 175	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT	566	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 566	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,529,850	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	620,437	31
32	Health Care	1,321,590	32
33	General Administration	789,896	33
	B. Capital Expense		
34	Ownership	594,467	34
	C. Ancillary Expense		
35	Special Cost Centers	121,977	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,502,570	40
41	**Income before Income Taxes (line 30 minus line 40)****	27,280	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 27,280	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,877	2,101	$ 55,221	$ 26.28	1
2	Assistant Director of Nursing	1,822	1,949	36,339	18.64	2
3	Registered Nurses	8,796	9,432	187,170	19.84	3
4	Licensed Practical Nurses	20,160	22,683	341,676	15.06	4
5	Nurse Aides & Orderlies	49,723	53,420	483,655	9.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,161	2,437	30,627	12.57	9
10	Activity Assistants	5,637	6,286	60,474	9.62	10
11	Social Service Workers	2,020	2,160	32,311	14.96	11
12	Dietician					12
13	Food Service Supervisor	1,959	2,451	29,281	11.95	13
14	Head Cook	6,843	7,807	57,760	7.40	14
15	Cook Helpers/Assistants	9,788	10,506	72,484	6.90	15
16	Dishwashers					16
17	Maintenance Workers	3,219	3,752	38,062	10.14	17
18	Housekeepers	9,981	11,124	87,597	7.87	18
19	Laundry	4,112	4,573	30,144	6.59	19
20	Administrator	1,843	2,207	68,648	31.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,921	2,092	28,392	13.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,794	2,043	28,201	13.80	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	133,656	147,023	$ 1,668,042 *	$ 11.35	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,280	1-3	35
36	Medical Director	O	1,200	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,529	10-3	39
40	Physical Therapy Consultant	L	2,823	10a-3	40
41	Occupational Therapy Consultant	Y	3,331	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	617	11-3	44
45	Social Service Consultant	E	1,386	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,166		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDY PREE	ADMIN	0	$ 68,648
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 68,648

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HEALTH DATA SYSTEMS	DATA PROCESSING	$ 2,499
SACHNOFF WEAVER	LEGAL	1,569
KRUPNICK, BOKOR, KAGDA	ACCOUNTING	12,752
FROST RUTTENBERG	ACCOUNTING	5,500
ECONOCARE	PURCHASING CONSLT	1,782
PERSONNEL PLANNERS	UC CONSULTANT	315
FOX RIVER FOODS	PURCHASING CONSLT	1,000
MANPOWER	EMPLOYMENT	3,787
	ACCT COLLECTION FEES	584
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 29,788

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,375
Unemployment Compensation Insurance	10,259
FICA Taxes	124,625
Employee Health Insurance	157,150
Employee Meals	15,586
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	14,400
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 358,395

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,330
Health Care Worker Background Check	231
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	26,052
RELATED PARTY	787
CONTRIBUTIONS	2,750
DUES & SUBSCRIPTIONS	5,124
LICENSES & PERMITS	910
CONTRIBUTIONS	(2,750)
Less: Public Relations Expense	(0)
Non-allowable advertising	(26,052)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,582

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	3,607
RELATED PARTY	642
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,249

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? _____

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LONG TERM CARE $ 2,111.

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 14,069 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? NO YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 54,203
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 15,586 Has any meal income been offset against related costs? NA Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: GILMAN NURSING PAVILION **#0044263** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,280	
	REPAIRS & MAINTENANCE		71	
			0	5,351
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,329	
			0	1,329
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		653	
	ELECTRICITY		61,369	
	WATER		19,205	
	CABLE TV - LOBBY		0	
			0	81,227
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,120	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,909	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		570	
	FIRE SERVICE		0	
			0	
			0	
			0	4,599
7	**OTHER**			
	SCAVENGER		5,968	
	SECURITY SERVICE		0	5,968
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,200	1,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	1,529	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	1,529
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,823	
	OCCUPATIONAL THERAPY CONSULTAI	XVIII B 41-2	3,331	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	6,154
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	617	
			0	617
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,386	
			0	1,386
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	1,062	1,062

Facility Name & ID Number GILMAN NURSING PAVILION **#0044263** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		403	403
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	2,499	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	26,705	
	ACCOUNT COLLECTION FEE		584	29,788
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	26,052	
	EMPLOYEE WANT ADS	XIX F	1,330	
	CONTRIBUTIONS	VI 20 XIX F	750	
	DUES & SUBSCRIPTIONS	XIX F	5,124	
	LICENSES & PERMITS	XIX F	1,110	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,000	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	231	36,597
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		257	
	EQUIPMENT REPAIR & MAINTENANCE		4,570	
	OUTSIDE CLERICAL SERVICES		160,780	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		7,519	
	MESSENGER SERVICE		0	

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	124,625	
	UNEMPLOYMENT COMPENSATION	XIX D	10,259	
	WORKERS COMPENSATION INSURANC	XIX D	36,375	
	HOSPITALIZATION INSURANCE	XIX D	157,150	
	EMPLOYEE BENEFITS - OTHER	XIX D	14,400	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	342,809
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,607	
	TRAVEL	XIX G	0	
			0	
			0	3,607
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		7,734	7,734
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		77,893	77,893
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 782,379

GILMAN NURSING PAVILION
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	131,736
LESS SALES TAX	(963)
NET FOOD	130,773
TOTAL PATIENT CENSUS	31,421
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	94263
ADD # EMPLOYEE MEALS/DAY	35
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	12775

PATIENT MEALS	94263
ADD EMPLOYEE MEALS	12775
TOTAL MEALS/YEAR	107038
NET FOOD	130773
DIVIDE TOTAL MEALS/YEAR	107038
COST PER MEAL	1.22
TIME EMPLOYEE MEALS	12775
EMPLOYEE MEAL RECLASSIFICATION	15586